

# Medway NHS Foundation Trust

## Quality Report

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Date of inspection visit: 29, 30 November 5,8,10 and  
17 December 2016.  
Date of publication: 17/03/2017

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

<b>Overall rating for this trust</b>	<b>Requires improvement</b> 
Are services at this trust safe?	<b>Requires improvement</b> 
Are services at this trust effective?	<b>Good</b> 
Are services at this trust caring?	<b>Good</b> 
Are services at this trust responsive?	<b>Requires improvement</b> 
Are services at this trust well-led?	<b>Good</b> 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Medway Maritime Hospital is located in Gillingham, Kent. The trust primarily serves a population of 384,300 people in the Medway and Swale area. The health of people in Medway Unitary Authority is mixed with 13 national indicators of health scoring better and six worse than the England average. Deprivation is similar to the England average and about 11,085 children (21%) live in poverty. Life expectancy for both men and women is lower than the England average.

The trust has a total of 655 beds spread across various core services of which 19 are surgical day case beds. The complement of in-patient beds comprises 300 medical beds 164 surgical beds 66 children's beds, 69 maternity beds and 25 critical care bed.

We inspected Medway NHS Foundation Trust on 29, 30 November 5,8,10 and 17 December 2016.

In 2011 and 2012 Medway NHS Foundation Trust was identified as a mortality outlier for both the hospital standardised mortality ratio (HSMR) and the summary hospital mortality indicator (SHMI). Consequently, Professor Sir Bruce Keogh (NHS England National Medical Director) carried out a rapid responsive review of the trust in May 2013. and the findings resulted in the trust being placed into special measures in July 2013. The Care Quality Commission (CQC) then undertook two comprehensive inspections of Medway Maritime Hospital in April 2014 and August 2015. The trust was rated inadequate overall at both of these inspections. In August 2015 the trust was rated inadequate overall because of concerns relating to patient safety, the organisational culture and governance throughout the trust. Since this inspection the CQC has maintained a heightened programme of engagement and monitoring of data and concerns raised directly with us. The trust had formalised a buddying agreement with Guys' and St Thomas' NHS Trust. The trust was also subject to additional scrutiny and support from the local clinical commissioning groups and NHSI through a monthly Quality Oversight Committee which monitored the implementation of action plans to address the shortcomings identified.

This inspection was specifically designed to test the requirement for the continued application of special measures at the trust.

We have now rated Medway NHS Foundation Trust as 'Requires Improvement' overall. Caring and effective and well led were rated as good whilst safe and responsive were rated as requires improvement. This is based on an aggregation of the ratings for the eight core services we inspected. We were able to see evidence of positive changes taking place across the hospital. However, there were still areas that required improvements to ensure patients received consistently safe care.

Our key findings were as follows:

### SAFE

- Incident reporting culture had been improved.
- Improvement in the assessment and documentation of patient risk had been delivered by a planned programme of training and enhanced risk assessment tools.
- The trust had ceased to care for patients within the emergency department corridor as a result of transformed ways of working within the emergency department.
- Major improvements had been achieved in the management of the estate and fire safety.
- Although staffing levels had significantly improved there were still areas operating below guidelines, notably in maternity and emergency care.
- The trust was not always meeting National Specifications for Cleanliness.
- Safeguarding and mandatory training targets were not being met consistently across the trust for all staff groups.

### EFFECTIVE

- Local audit was now taking place across all services.
- The trust had significantly improved its mortality rate and is no longer an outlier for the hospital standardised mortality rate (HSMR).
- Staff understanding of mental capacity was much improved.
- Appraisal rates across the trust had improved.

### CARING

- Maternity and gynaecology were rated as outstanding.

# Summary of findings

- Our observations during the inspection supported the data and the positive feedback received from patients and carers.
- Handover meetings on surgical wards were managed in a format that compromised patient dignity and privacy.

## RESPONSIVE

- Support to vulnerable patients such as those living with dementia and those with learning disabilities had been significantly improved.
- Service planning had led to the introduction of new pathways and services aimed at delivering enhanced care for patients.
- The trust still had a high number of patients who experienced mixed sex accommodation or were in beds not appropriate for their medical specialty.
- There was evidence of short notice surgical cancellations and delays in discharge from critical care.
- The trust was not meeting guidance for achieving and reporting referral to treatment times.
- Processes for the management of complaints had only recently been addressed to ensure the attainment of response targets.

## WELL LED

- The executive team was well established and performing as a highly cohesive unit with a shared vision and clarity of purpose.
- The national staff survey and our interviews with staff indicated a significantly improved organisational culture.
- Governance arrangements had been strengthened and there was a clear line of accountability.
- The strategic and recovery plans were well constructed and supported by appropriate programme management. Furthermore, these plans had been clearly translated into local divisional and service plans.
- There was a requirement to further develop service level leadership to ensure full engagement of the workforce.
- Strategies for the management of equality and diversity were under developed.
- There were services where staff felt exhausted and not involved in service level decision making.

We saw several areas of outstanding practice including:

- The neonatal unit improved their breast-feeding at discharge compliance rates from one of the lowest rates in the country to the highest. A critical care consultant, nurse practitioner, GP lay member and physiotherapist led an innovative programme to improve patient rehabilitation during their ICU admission and after discharge. This included a training and awareness session for all area GPs and a business case to recruit a dedicated rehabilitation coordinator. In addition, a critical care consultant had developed app software to be used on digital tablets to help communication and rehabilitation led by nurses. The consultant was due to present this at a critical care nurses rehabilitation group to gather feedback and plan a national launch.
- Critical care services had a research portfolio that placed them as the highest recruiter in Kent. Research projects were local, national and international and the service had been recognised as the best performer of the 24 hospitals participating in the national provision of psychological support to people in intensive care (POPPI) study. Research projects for 2016/17 included a study of patients over the age of 80 cared for in intensive care; a review of end of life care practices; a respiratory study and a study on abdominal sepsis.
- The 'Stop Oasis Morbidity Project' (STOMP) project had reduced the number of first time mothers suffering third degree perineum tears. The project had been shortlisted for the Royal College of Midwifery Award 2017, Johnson's Award for Excellence.
- Team Aurelia was a multidisciplinary team. Women who were identified in the antenatal period as requiring an elective caesarean section would be referred to team Aurelia. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.
- The bereavement suite, Abigail's Place, provided the "gold standard" in the provision of care for parents and families who experience a still birth. The suite created a realistic home environment for parents to spend time with their child.

## Summary of findings

- The frailty and the ambulatory services, which required multidisciplinary working to ensure the needs of this patient group, were met. The individualised care and pathway given to patients attending with broken hips. The care ensured this group of patients' needs were met on entering the department until admission to a ward. The development and implementation of the associate practitioner role.

However, there are a number of areas where poor practice was identified that require attention:

### Action the hospital **MUST** take to improve

- Ensure flooring within services for children and young people is intact, in accordance with Department of Health's Health Building Note 00-09.
- Ensure all staff clean their hands at the point of care in accordance with the WHO 'five moments for hand hygiene'.
- Review the provision for children in the recovery area of theatres and Sunderland Day Unit to ensure compliance with the Royal College of Surgeons, standards for children's surgery.
- Ensure staff record medicine fridge temperatures daily to ensure medicines remain safe to use.
- Ensure compliance with recommendations when isolating patients with healthcare associated infections.
- Ensure that all staff have appropriate mandatory training, with particular reference to adult safeguarding level two and children safeguarding levels two where compliance was below the hospital target of 80%. Ensure that all staff receive an annual appraisal.
- Ensure that an appropriate policy is in place ensuring that patients transferred to the diagnostic imaging department from the emergency department are accompanied by an appropriate medical professional.
- Ensure the intensive care unit meets the minimum staffing requirements of the Intensive Care Society, including in the provision of a supernumerary nurse in charge.
- Ensure staffing levels in the CCU maintain a nurse to patient ration of 1:2 at all times.
- Ensure that consultant cover in the emergency department meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.
- Ensure fire safety is a priority. Although the trust has taken steps to make improvements we found some areas where fire safety and staff understanding needed to be improved.

# Summary of findings

- The trust must ensure people using services should not have to share sleeping accommodation with others of the opposite sex. All staff to be trained and clear of the regulation regarding same sex accommodation.
- Ensure clinical areas are maintained in a clean and hygienic state, and the monitoring of cleaning standards falls in line with national guidance. Take action to ensure emergency equipment (including drugs) are appropriately checked and maintained.

## Action the hospital SHOULD take to improve

- Ensure the electronic flagging system for safeguarding children in the children's emergency department is fully embedded into practice. Review safeguarding paperwork to ensure it can be easily identified in patient's records.
- Ensure there is a system in place to identify Looked after Children (LAC) in the children's emergency department.
- Enhance play specialist provision in line with national guidance.
- Ensure children's names and ages or not visible to the public, in compliance with the trusts 'Code of conduct for Employees in Respect of Confidentiality' policy.
- Ensure compliance with NICE QS94, and ensure children, young people and their parents or carers are able to make an informed choice when choosing meals, by providing them with details about the nutritional content.
- Identify risks for the outpatient risk register.
- Ensure that referral to treatment times improve in line with the national targets.
- Monitor the turnaround times for production of clinic letters to GPs following clinic appointments. Ensure there is sufficient resource in allied health professionals teams to meet the rehabilitation needs of patients.
- Ensure medical cover in the CCU is provided to an extent that nurses are fully supported to provided safe levels of care.
- Medicines and IV fluids should be stored securely and safely. Intravenous (IV) fluids were stored in a draw on a corridor on pearl ward this was not secure as it did not ensure that IV fluids could not be tampered with. We found ampoules of metoclopramide and ranitidine, drugs commonly used for stomach problems, stored in a box together. This created a risk that patients may have been given the incorrect medicine.
- Ensure equipment cleaning is thorough, including the undersides of equipment.

## Summary of findings

- Ensure complaints are responded to in accordance with the trust's policy for responding to complaints.
- Meet the national standards for Referral to treatment times (RTT) for medical care services and continue to reduce the average length of stay of patients.
- The driving gas for nebulised therapy should be specified in individual prescriptions as can be harmful to the patient.
- Continue to address issues with flow to improve performance against national standards.
- Repair/replace the two patient call bells in the majors overflow area.
- Install a hearing loop in the emergency department reception area.
- Consider how staff are made aware of internal escalation processes.
- Take action to ensure patients recover from surgery in appropriate wards where their care needs can be met.
- The trust should take action to ensure there is sufficient access to equipment. In particular, sufficient sling hoists for patients on Arethusa and Pembroke Wards and sufficient access to computers for staff throughout the surgical directorate.

There is no doubt that substantial improvements have been made since our last inspection. The leadership team is now fully established and there is a strong sense of forward momentum and control. In addition it is clear that strong leadership and clear communication are leading to an engaged workforce whose morale is now much higher.

It is apparent that the trust is on a journey of improvement and significant progress is being made both clinically and in the trust's governance.

I would therefore recommend that, from a quality perspective, Medway NHS Foundation Trust, is now taken out of special measures.

**Professor Sir Mike Richards** Chief Inspector of Hospitals

# Summary of findings

## Background to Medway NHS Foundation Trust

Medway Maritime Hospital is located in Gillingham, Kent. The trust primarily serves a population of 384,300 people in the Medway and Swale area. The health of people in Medway Unitary Authority is mixed with 13 national indicators of health scoring better and six worse than the England average. Deprivation is similar to the England average and about 11,085 children (21%) live in poverty. Life expectancy for both men and women is lower than the England average.

The trust has a total of 655 beds spread across various core services of which 19 are surgical day case beds. The complement of in-patient beds comprises 300 medical beds, 164 surgical beds, 66 children's beds, 69 maternity beds and 25 critical care beds.

Medway NHS Foundation Trust has five registered locations, the Medway Maritime Hospital, Woodlands

Special Needs Nursery, and the Orchards Centre. On this occasion we only inspected the Medway Maritime Hospital. In addition to standard specialties at the trust the trust provides the following specialist services: Macmillan cancer care unit, West Kent centre for urology, West Kent vascular centre, regional neonatal intensive care unit, foetal medicine unit and stroke services for the local population.

In the 2015/16 financial year, the trust had an income of £255,017,000 and costs of £307,531,000. This has resulted in a deficit of £52,514,000. The trust predicts it will have a deficit of £43,839,000 in 2016/17. Whilst the financial situation impacts on how the trust provides services, CQC does not report on this aspect of the trust's work. Our remit is to focus on the quality and safety of the services that are being provided.

## Our inspection team

Our inspection team was led by:

Chair: Dr Martin Cooper

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team of 44 included CQC managers and inspectors and a variety of specialists including doctors, consultants, a consultant paediatrician, a consultant obstetrician and

gynaecologist, a consultant in emergency medicine, a professor of respiratory medicine and patient centred care, lead nurse specialist in pain management, consultant nurses, lead and specialist nurses and matrons, consultant midwives, senior NHS managers including directors of estates and facilities, along with a pharmacist, a radiographers and two experts by experience.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at the Medway Maritime Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people

## Summary of findings

- End of life care
- Outpatients and Diagnostic Imaging

Before the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Local Area Team (LAT), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch. We carried out the announced inspection visit between 29 and 30 November 2016. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student

nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually when they requested this.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections on 5,8,10 and 17 December 2016. We looked at how the hospital was run out of hours and, the levels and grades of staff available and the care provided.

## Facts and data about this trust

Between April 2015 and March 2016 the trust had 83,326 A&E attendances, 63,459 inpatient admissions, 495,999 outpatient attendances, 4,920 births and 975 referrals to the specialist palliative care team.

As at September 2016, the trust employed 3,747.2 whole-time equivalent (WTE) staff out of an establishment of 4,506 WTE. The overall vacancy rate at the trust was 16.84%. The trust's sickness levels between May 2015 and April 2016 were generally lower than the England average. Sickness levels ranged from a low of 3.2% in May 2015 to a high of 4.5% in October 2015.

Nursing and Midwifery staffing recorded in September 2016 showed there were 1,055.9 WTE nursing and midwifery staff in post which represented 75% of the planned establishment. The trust target for vacancy rate is 8%. As at July 2016 the trust reported a vacancy rate of 25% for nursing and midwifery staff which was well above the trust target. The trust target for turnover rate is 8%. Between October 2015 and September 2016 the trust reported a turnover rate of 12% for nursing and midwifery staff which was above the trust target. The trust target for sickness rate is 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 4% for nursing and midwifery staff in line with the trust target.

Medical staffing recorded in September 2016 showed there were 462.9 WTE medical staff in post which represented 83% of the planned establishment. The trust

target for vacancy rate is 8%. As at July 2016 the trust reported a vacancy rate of 17% for medical and dental staff which was above the trust target. The trust target for turnover rate is 8%. Between October 2015 and September 2016 the trust reported a turnover rate of 5% for medical and dental staff which was below the trust target. The trust target for sickness rate is 4%. Between October 2015 and September 2016 the trust reported a sickness rate of 0.7% for medical and dental staff which was below the trust target.

The proportion of consultant staff reported to be working at the trust was lower than the England average (36% compared to the England average of 42%) and for junior (foundation year 1-2) staff it was higher than the England average (17% compared to the England average of 14%).

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between September 2015 and August 2016 the trust reported no incidents which were classified as never events.

The trust reported 58 serious incidents (SIs) which met the reporting criteria set by NHS England between



## Summary of findings

September 2015 and August 2016 in accordance with the Serious Incident Framework 2015. Of these, the most common type of incident reported was slips, trips and falls (24%).

There were 4,752 incidents reported to The National Reporting and Learning System (NRLS) between July 2015 and June 2016. The Patient Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data from the Patient Safety Thermometer showed that the trust had reported 85 pressure ulcers, 15 falls with harm and 26 urinary tract infections in patients with a catheter between August 2015 and August 2016. The prevalence rate of pressure ulcers over time has reduced which may have resulted due to a change in processes.

There were four cases of MRSA reported between August 2015 and July 2016. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within the period. Additionally, the trust reported 18 MSSA infections and nine C.Difficile infections over the same period.

The trust supplied their training completion data as of 18 October 2016. The board performance report states that the trust target for mandatory training (including safeguarding training) is 80%. The trust did not provide the data by staff group. With regard to safeguarding training, 76% of staff had completed safeguarding adults level 1, which was below the trust target. Seventy seven percent of eligible staff had completed safeguarding adults level 2, which was below the trust target. Eighty nine percent of staff had completed safeguarding children level 1, which was above the trust target, however 76% of eligible staff had completed safeguarding children level 2, which was below the trust target. Eighty three percent of eligible staff had completed safeguarding children level 3, which was better than the trust target.

All Deprivation of Liberty (DOLS) training at the trust is delivered as part of the mandatory adult safeguarding modules. As at 18 November 2016 81.4% of staff had completed Mental Capacity Act (MCA) training.

The trust supplied training completion data as of 18 October 2016. The trust did not provide the data by staff

group. The data shows that overall training completion was at 83%, above the trust target. Eight out of 18 modules fell below the 80% target. These modules included adult life support (69%), infection control level 2 (70%), manual handling – 5 year (78%), newborn life support (69%), paediatric life support (62%).

The trust target for completion of staff appraisals was 95%. Between April 2015 and March 2016 the trust reported a staff appraisal completion rate of 73% and between April 2016 and September 2016 the appraisal rate was 78%, both below the trust target.

Some staff are required to complete Emergency Preparedness Resilience and Response (EPPR) training. As at 21 November 2016 1,067 staff had completed this training, however the trust did not provide figures for how many staff required this training.

As at 6 September 2016 there were four outstanding mortality alerts where action plans were being followed up by the local inspection team. Mortality alerts are raised when there is a trends in the death rate for specific conditions or operations. There were alerts were for the following categories: Chronic obstructive pulmonary disease and bronchiectasis (Dr Foster, Sep 13, Fluid and electrolyte disorders (Dr Foster, Dec 13), Intestinal obstruction without hernia (Dr Foster, Nov 13, Septicaemia (except in labour) (Dr Foster, Sep 12). Following our inspection all four cases were closed.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for four of the 34 questions, in the middle 60% for 16 questions and in the bottom 20% for 14 questions.

The trust performed in the top 20% of trusts for possible side effects explained in an understandable way, patient given the name of the clinical nurse specialist in charge of their care, GP given enough information about patient's condition and treatment and patient did not think hospital staff deliberately misinformed them.

The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to cleanliness and worse than the England average for food, privacy, dignity and wellbeing and facilities. Performance relating to food and privacy, dignity and respect deteriorated by 10% in 2016 compared to 2015 whilst performance relating to facilities improved by 7%.

## Summary of findings

In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for 11 questions out of 12. There was no data available for the trust for the remaining question relating to discharge delays.

The trust was one of the best performing hospitals for rates of delayed discharges. The main reasons for delayed transfer of care at the trust between August 2015 and July 2016 were patient or family trust (. 34% compared to an England average of 13%), followed by waiting further NHS non-acute care (17% compared to an England average of 18%).

Bed occupancy rates were consistently above the England average between Q3 2014/15 and Q4 2015/16 with rates ranging from 95.5% in Q3 2014/15 to 99.7% in Q2 2015/16.


Between August 2015 and July 2016 the trust took an average of 77 days to investigate and close complaints. This was not in line with the trust's complaints policy which sets a target response time of 30 days, unless the complainant agrees to a longer period.. However, the trust had worked hard to clear the complaints backlog which they had completed by the date of our inspection.

Sixty eight per cent 68% of complaints with an outcome were upheld, 14% (54) were partially upheld and 18% were not upheld. The most common area for complaint was the outpatients department (115 complaints) followed by the accident & emergency department (97 complaints). The most frequently occurring themes were lack of care/attention and treatment (mentioned in 168 complaints) and the attitude of nursing staff (mentioned in 43 complaints).

In the NHS Staff Survey 2015, the trust performed about the same as other trusts in 11 questions and worse than other trusts in 21 questions. When compared to the 2015 results the 2016 staff survey showed significant improvements have been made with 44 significant results that were better than the previous survey and one which was worse. It should be noted the 2015 results for Medway were very poor. Therefore, despite the 44 significant improvements the trust still performs poorly compared to the average. For example, the "Your Organisation" section saw 5 of the 7 indicators improve significantly compared to the previous year. However compared to the average 4 of the 7 are still significantly lower than the average.

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>Following our inspection of August 2015 the trust was rated as inadequate for safety. At that time emergency services, medical care, surgery and outpatients and diagnostics were all rated as inadequate.</p> <p>Our findings on this inspection led us to improve that rating to one of requires improvement. This is because:</p> <ul style="list-style-type: none"> <li>• There were no longer any services rated as inadequate for safety.</li> <li>• Incident reporting culture had been improved.</li> <li>• Improvement in the assessment and documentation of patient risk had been delivered by a planned programme of training and enhanced risk assessment tools.</li> <li>• The trust had ceased to care for patients within the emergency department corridor as a result of transformed ways of working within the emergency department.</li> </ul> <p>However:-</p> <ul style="list-style-type: none"> <li>• Although staffing levels had significantly improved there were still areas operating below guidelines.</li> <li>• The trust was not always meeting National Specifications for Cleanliness.</li> <li>• Safeguarding and mandatory training targets were not being met consistently across the trust for all staff groups.</li> </ul> <p><b>Incidents</b></p> <ul style="list-style-type: none"> <li>• The 2015 inspection identified major concerns relating to the reporting, investigation and learning from incidents.</li> <li>• This inspection identified a much improved culture of incident reporting. In addition processes for communicating and learning from incidents were largely consistent across the trust.</li> <li>• Our review of root the cause analysis of serious incidents indicated robust, well constructed investigations. Subsequent action plans were detailed with clearly aligned responsibility for action.</li> <li>• The trust had employed a number of communications methods to enhance opportunities for learning from incidents. As a result staff were largely clear about the actions arising from incidents.</li> <li>• In critical care the processes for learning from incidents do however require improvement where staff received inconsistent feedback on incidents.</li> </ul>	<p><b>Requires improvement</b> </p>

# Summary of findings

- The diagnostic imaging department were now ensuring prompt reporting of incidents relating to ionising radiation exposure.
- The monitoring of mortality and morbidity was highly profiled within the trust, however minutes relating to mortality and morbidity meetings lacked clear actions in surgery.

## **Duty of Candour**

- Duty of candour was well understood by staff and we saw evidence of the trust discharging this duty following incidents.

## **Cleanliness, infection control, equipment and environment**

- The trust had an appropriately resourced infection control team with links to the board via an appointed director of infection prevention and control (DIPC).
- The DIPC chaired the Infection and Antimicrobial Stewardship Committee. This meeting had appropriate cross trust membership and reported on a regular basis to the Quality Improvement Group.
- The trust had up to date infection control policies and our inspection indicated that staff were clearly aware of the policy content.
- During the inspection we observed staff adhering to hand hygiene protocols. Personal protective equipment was readily available and used appropriately by staff.
- The trust carried out regular hand hygiene audits. These audits indicated a high level of compliance although inconsistent practice had been identified in the emergency department.
- Governance and management arrangements relating to estates and facilities management had been significantly strengthened and this has improved the management of a challenging estate. The trust was largely visibly clean however, our inspection identified instances where the auditing of clinical environments were not meeting the requirements set out in the National Specifications of Cleanliness (NSC).
- Despite the challenging estate, clinical areas were largely of adequate design and afforded an appropriate clinical environment. The trust had identified key areas of concern, notably in the emergency department, and had commenced a capital programme of improvement.
- Action had been taken following our previous reports concerns regarding fire safety, leading to enhanced training, policies and improved fire safety of the estate. Occasional lapses did occur and we observed the blockage of safe exits by equipment in cardiac critical care.

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- Staff reported appropriate access to medical equipment and equipment was suitably checked and maintained. Although improvements to the ward environment had generally provided more organised storage, some areas were congested notably in the critical care unit.

## Safeguarding

- The trust had up to date policies for adult and child safeguarding. Safeguarding had board level representation via the chief nurse who was supported by a head of safeguarding. The board received an annual safeguarding report.
- There was an appropriate and inclusive governance structure for safeguarding that links with external stakeholders.
- Staff were aware of how to contact safeguarding team members and there was indication from staff that policies had been improved. Staff were aware of their safeguarding responsibilities and how to discharge them, including issues such as female genital mutilation.
- A comprehensive training programme was in place. However, not all services were attaining the trust target for attendance with medical staff compliance being generally lower than that for other staff groups.

## Staffing

- During our last inspection staffing levels were a cause for significant concern. The trust has managed to improve the position by a combination of recruitment strategies, that have dramatically reduced nursing vacancy rates, and the use of temporary staff. This means that even in particularly challenged areas such as medicine, safe staffing levels are being maintained, albeit with high temporary staff usage.
- Medical staffing in the emergency department did not meet royal college guidelines, particularly at weekends. In addition nursing cover was limited for staff in resuscitation leading to less than optimum patient staff ratios during breaks.
- In surgery staff reported a feeling of improvement, however a high vacancy rate remains and 26% of shifts had less staff than planned.
- Similar pressures were observed in critical care where there was an inability to maintain a supernumerary nurse. The cardiac care unit also struggled to maintain the required patient staff ratio or avoid lone working particularly when bed numbers were escalated.

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- Continued midwifery staffing pressures resulted in patient to staff ratios that did not meet the recommendations of birthrate plus. 97% of women received 1:1 care whilst in labour from November 2015 to October 2016.

## Assessment of patient risk

- Our previous inspection detailed significant failings with respect to the management and documentation of patient risk and the treatment of deteriorating patients.
- This had been subject to focussed effort by the trust and the introduction of the deteriorating patient programme board and an extensive training and communications plan. An acute response team had been reformed from the critical care outreach team.
- Within the emergency department we observed significantly improved processes. There was now a consistent approach to triage and the use of early warning scores. Documentation was much stronger and subject to formal audit in addition to medical and nursing safety rounds. However, diligence is required to ensure that sepsis assessment and management is provided in a consistent manner.
- The management of patient risk within the emergency department had been significantly improved by the transformation of department processes which led to the cessation in the use of corridor areas for patient care.
- This had been further supported by the introduction of a more responsive medical model, pathways for frail elderly and access to ambulatory care and rapid clinics all of which have contributed to ensuring that patients are cared for in the most appropriate environment.
- Across the trust the use and documentation of early warning scores had been enhanced and supported by the use of audit and regular safety huddles. Staff were aware of escalation processes and referral routes to the acute response team.
- In surgery the five steps to safer surgery were well embedded and pre assessment processes appropriate.

## Medicines

- At our last inspection evidence of the safe management and control of medicines was not strong. This report indicated that significant improvement had been made in all areas of medicines management.
- The trust had up to date policies to provide staff with guidance in medicines management.

# Summary of findings

- The trust had a list of critical medicines and communication to staff had been made to highlight the importance of these medicines.
- Medicines were held in a secure manner across the trust including controlled drugs. Storage temperatures were largely monitored, however some areas were not aware of the impact of high ambient temperatures the subsequent need for this to be monitored.
- Medicine stocks were regularly reviewed to avoid out of date drugs and processes for the management of waste medicines appropriate. However, some out of date drugs were identified on one anaesthetic trolley.
- The trust had a number of patient group directives in place and all had been reviewed and were in date.
- Where in use, FP10 prescribing forms were securely kept.

## Records

- In most services, records were comprehensive in content, in good order and securely kept.
- Our inspection identified evidence of audit of notes content and action where appropriate.

## Are services at this trust effective?

Following our inspection of August 2015 the trust was rated as requires improvement for being effective.

Our findings on this inspection led us to improve that rating to one of good. This is because:

- All services were rated as good for being effective.
- Local audit was taking place across all services.
- The trust had significantly improved its mortality rate and is no longer an outlier for the hospital standardised mortality rate (HSMR).
- Staff understanding of mental capacity was much improved.
- Appraisal rates across the trust had improved.

## Evidence based care and treatment

- Policies and procedures were in place, reviewed and in date across all services and were underpinned by evidence based practice.
- All services had a programme for the completion of national audits. This activity was further supported by extensive local audit.

Good



# Summary of findings

- Our inspection identified evidence of discussion at team meetings and display of audit results to engage staff in the process.
- There was evidence of participation in national accreditation schemes notably for endoscopy and pathology services.

## Patient Outcomes

- The trust was not an outlier for hospital standardised mortality rate (HSMR) or the summary level mortality indicator (SHMI).
- The trust participated in the Royal College of Physicians end of life care audit in 2016. The trust performed well against the national averages for clinical indicators but results in the organisational performance indicators showed a need for further development. The trust had an action plan to address these deficiencies.
- The trust contributed to the Trauma Audit and Research Network (TARN) and results indicated above average results against national performance.
- However, local audit data indicated that only 53% of patients on the sepsis pathway met the full range of national guidance.
- The trust achieved a grade of D in the Sentinel Stroke National Audit Programme (SSNAP) but did perform well in the national heart failure audit.
- Surgical national audit data was largely positive and did not feature any outliers and outcomes for patients with fractured hips were in line, and in some cases better, when compared with national results.
- Results for maternity services indicated the trust was operating within expected ranges for caesarean section, neonatal admissions and puerperal sepsis. The number of third or fourth degree tears was also within limits.

## Competent Staff

- All services had a clear process for the development and maintenance of staff competence. This included schemes to provide mentorship, competency frameworks and comprehensive induction.
- Although the trust was very reliant on a temporary workforce, control processes including policies and induction were in place to ensure temporary staff capability.
- There was a comprehensive range of specialist nurses and midwives to provide support to patients, particularly those from vulnerable groups.
- Processes for ensuring registration and revalidation of staff were well established.



# Summary of findings

- Although appraisal rates for staff within the trust were on an upward trend there is still a requirement for further improvement with a number of services, and nursing overall, being below target.

## **Consent, Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).**

- Processes for obtaining consent were appropriately controlled and well documented including those for children.
- Staff awareness of mental capacity and DoLS was largely good, however some services were not attaining training targets.

## **Are services at this trust caring?**

Following our inspection of August 2015 the trust was rated as good for being caring.

Our findings on this inspection led us to maintain that rating of good. This is because:

- All services, with the exception of surgery and maternity and gynaecology were rated as good. Surgery was rated requires improvement and maternity and gynaecology as outstanding.
- Our observations during the inspection supported the data and the positive feedback received from patients and carers.
- Handover meetings on surgical wards were managed in a format that compromised patient dignity and privacy.

## **Compassionate Care**

- Staff placed compassionate patient care as a priority in their work. During the inspection we observed numerous interactions between staff and patients which placed patient welfare and dignity at its heart.
- However, on surgical wards we saw a process for handover of care which was not consistent with the positive practice across the trust and compromised patient dignity and privacy. Due to the nature of this practice it was not an isolated incident and impacted on all patients on the ward.
- The trust had developed a bereavement centre to support families following stillbirth or neonatal death. This unit, named Abigail's Place, provided privacy and compassionate support and was seen as outstanding practice.
- Data from the Friends and Family test survey supported our positive observed findings.

**Good**



# Summary of findings

## Understanding and involvement of patients and those close to them

- We spoke to a number of patients and carers during the inspection. All described interactions that ensured that they were appropriately involved in care plans. They also indicated that care plans were well communicated to them by staff.
- Vulnerable patients were particularly well considered for and we saw examples of excellent interactions between staff caring for patients with learning disabilities and patients living with dementia.

## Emotional support

- Staff were aware of emotional support and needs of patients and were able to access multi-faith support for patients from the chaplaincy.
- Of particular note was the assessment of patients in critical care by occupational therapy to ascertain any requirement for stress or anxiety management during recovery.

## Are services at this trust responsive?

Following our inspection of August 2015 the trust was rated as inadequate for being responsive. At this time emergency services, medical care, and outpatients and diagnostics were all rated as inadequate.

Our findings on this inspection led us to improve that rating to one of requires improvement. This is because:

- No services were rated as inadequate for being responsive.
- Support to vulnerable patients such as those living with dementia and those with learning disabilities had been significantly improved.
- Service planning had led to the introduction of pathways and services aimed at delivering enhanced care for patients.

However;

- Patient flow in all clinical services was challenging.
- The trust still had a high number of patients who experienced mixed sex accommodation or were in beds not appropriate for their medical specialty.
- There was evidence of short notice surgical cancellations and delays in discharge from critical care.
- The trust was not meeting guidance for achieving and reporting referral to treatment times.
- Processes for the management of complaints had only recently been addressed to ensure the attainment of response targets.

**Requires improvement**



# Summary of findings

## Service planning

- Since our last inspection the trust has made extensive consideration of service configuration and planning. The subsequent introduction of a new medical model, ambulatory care pathways, fractured neck of femur and frail elderly care pathways have proved strong examples of the introduction of new systems to enhance patient care and safety.
- The trust and services met regularly with commissioners and other providers (including ambulance services) to plan services.
- The trust worked very closely with a community health trust to plan and deliver both end of life care and hospital discharge.

## Meeting Individual Needs

- At our inspection in August 2015 we reported a lack of support to meet the needs of patients living with dementia. This had been significantly improved. Staff awareness, methods of identification and communication, the availability of link nurses had all been developed. The environment had also been improved and included access to sensory rooms.
- Bathrooms and toilets had been adapted to support patients with limited mobility and appropriate equipment was available to support bariatric patients.
- A learning disability team had been developed and staff were aware of how to access and take advice from the team. During the inspection we saw the use of modified communication tools and patient passports to support patients with learning disabilities.
- Wards across the trust applied protected meal times and staff ensured that patients were fully supported to obtain nutritional needs.
- Patients with mental health needs were well supported and the trust made good use of agency nurses with mental health skills.
- In critical care we saw excellent support to patients in rehabilitation and a novel approach to supporting patients wellbeing through pet therapy.
- The trust was proactive in its support of breastfeeding and was UNICEF baby friendly accredited.
- Translation services were available and had been tailored to reflect the needs of the largest local ethnic minority groups.

## Access and Flow

- High acuity and growing activity levels in all services continued to create issues of flow through the trust.
- Despite the major improvements in flow management within the emergency department, and the cessation of the usage of

## Summary of findings

the corridor area for care, the trust was not attaining the four hour standard. In addition, the number of patients waiting between 4 and 12 hours for admission was on a deteriorating trajectory. The trust was above(worse than) the national average for patients leaving the department without treatment.

- A further impact of patient flow issues was the high number of patients not being cared for in single sex accommodation. In addition patients were often cared for in beds other than the specialty whose care they were under. An excessive number of patients were being moved from one ward to another after 10pm.
- The rate of cancelled elective operations was improving but was still worse than the national average. Theatre operating start time was often delayed, and although showing a trend of improvement, we saw examples when patients were cancelled on the day of their operation.
- The trust had not reported against the national referral to treatment standards since 2014. A process of data validation and review continued, however data available indicated that many services were not currently meeting the standard.
- There were significant delays in patients being discharged from intensive care units back to wards once fit to do so, with many experiencing a delay in excess of 24 hours and some patients being discharged directly to home.
- The maternity unit had closed on seven occasions in between April 2015 and July 2016 often as a result of the neonatal unit reaching capacity. Each time the closure had been fully reviewed and appropriate decision making taken.

### Learning from complaints

- The trust had endured consistent problems in the 12 months preceding the inspection in meeting its response time target. The delays incurred in responding would have reduced the opportunity of prompt learning from complaints. However, the management framework and supporting infrastructure had now been changed and the back log removed.
- At a corporate level we saw an appropriate governance and communications structure that supported learning from complaints.
- During the inspection we saw evidence in all services of processes of trend analysis and learning from the outcomes of complaints and audits.

# Summary of findings

## Are services at this trust well-led?

Following our inspection of August 2015 the trust was rated as inadequate for well-led. At this time emergency services, medical care, surgery, end of life care and outpatients and diagnostics were all rated as inadequate. Corporate leadership was also rated inadequate.

Our findings on this inspection led us to improve that rating to one of good.

This is because:

- The executive team was well established and performing as a highly cohesive unit with a shared vision and clarity of purpose.
- The national staff survey and our interviews with staff indicated a significantly improved organisational culture.
- Governance arrangements had been strengthened and there was a clear line of accountability.
- The strategic and recovery plans were well constructed and supported by appropriate programme management. Furthermore, these plans had been clearly translated into local divisional and service plans.

However;

- There was a requirement to further develop service level leadership to ensure full engagement of the workforce.
- Strategies for the management of equality and diversity were under developed.
- There were services where staff felt exhausted and not involved in service level decision making.

## Leadership of the trust

- Following our inspection in August 2015 we reported that the trust leadership was still built on interims, there was a lack of confidence in the board from the consultant body and the workforce in general and that leaders were not visible in the organisation. At a divisional level many posts remained unfilled and there was a lack of clinical leadership.
- The leadership team had developed into a highly effective and cohesive unit. Key to this transition has been the leadership skills of the chief executive who has developed a team that is clear of its direction and of each individual's role in delivery of strategy. There is a very strong sense of teamwork within the executive.
- The 'buddying arrangement' has transitioned from one of attendant advisors to one of fully integrated team members.

Good



## Summary of findings

This had led to the substantive appointment of both chief nurse and medical director from the 'buddying organisation' indicating a clear commitment to further successful transformation of the trust.

- Clinical leadership has been central to the delivery of change within the trust. The medical director, with support from colleagues from the buddying trust, have successfully led change whilst ensuring ownership has been maintained by the clinicians within the trust.
- Nursing leadership has been strengthened and was reflected in a focus on standards of care and delivery of quality.
- Both the financial and human resource agenda are challenging and the trust had appointed high quality candidates into posts, albeit the finance director is currently interim.
- Immediately prior to the inspection the trust chair resigned. An experienced interim had been put in place swiftly and there had been no interruption to trust improvement progress.
- Our interviews with non executive directors indicated a requirement for development, particularly in the differentiation of non-executive and operational management function. All non- executive directors were committed to improvement and acknowledged the position which the trust had come from, however they did not provide evidence of a shared vision.
- Non-executive directors visited clinical areas and there was a process for feedback.
- During the inspection we met with the trust governors. Compared with the August 2015 inspection the group were much less divided and the lead governor was providing direction. There remained a need for development of purpose but there was clear support for the executive team and the rate of improvement across the trust.
- Stakeholders described the trust leadership as open and engaging when working with them and aware of risks and challenges to service provision and quality.
- Staff focus groups, including medical consultants, acknowledged the support and visibility of the management team. Many staff commented on the positive nature of the now 'consistent and committed leaders' after many years of management change fatigue.
- Management at a divisional level had also significantly strengthened with the appointment of divisional directors of operations who work in conjunction with a deputy medical director and deputy director of nursing. Staff in all services reported a much greater clarity and purpose to management.

# Summary of findings

- In addition the appointment of a director of estates and facilities has brought rigour to addressing site and fire safety issues.
- A programme of clinical leadership has been established and is on-going. The medical director and the nursing director co-chaired a clinical council which provided a forum to promote the development and delivery of the trust clinical strategy.
- Future clinical leadership was being addressed by the MediLead programme which aimed to develop management skills for junior doctors.
- The development of management capability below divisional level still required attention with some services describing a lack of communication and involvement in decision making.

## Vision and strategy

- Following our inspection in August 2015 our findings were that both strategy and recovery plan were poorly understood in the workforce and that the consultant body were poorly engaged in development and delivery of the strategy.
- The trust had revised its vision, values and strategic objective in the last twelve months. This has been an inclusive process supported by engagement of more than 600 staff.
- The trust vision of 'best of care, best of people' is widely signposted across the organisation and features in all communications. Similar focus and attention is paid to the trust values of 'bold, every person counts, sharing and open and together - BEST'.
- During our interviews with staff and the staff focus groups we held we tested staff understanding and engagement with the trust values. Many staff clearly articulated what the values meant to them personally and the way they deliver care however, this was not wholly consistent with one service indicating a lack of connection and involvement in the values development.
- The trust had four strategic objectives relating to our people, innovation, integrated healthcare and financial stability.
- The trust had developed a detailed recovery programme. Unlike at our inspection of 2015 the recovery was well understood at both divisional and departmental level with local recovery plans and strategies being aligned with the trust wide plan.

# Summary of findings

## **Governance, risk management and quality measurement**

- Our findings during the August 2015 inspection indicated that there was an inconsistent approach to governance, risk management and performance measurement across the trust.
- Alongside the revised divisional management structure, the trust governance structure had been significantly strengthened since our last inspection.
- The board met on a regular basis in private and in public settings. Board papers were comprehensive in content and well supported by data. Non executive directors indicated a need to reduce quantity and raise the quality of board papers.
- The trust had clear lines of accountability. The trust had appropriate board sub committees that are chaired by non-executive directors. Terms of reference had been reviewed and were up to date.
- Meeting structure and content allowed clear analysis of performance, workforce, risk and finance and provided the board with clear sight of issues.
- Divisional meetings were similarly well structured and organised with good use of monthly dashboards and allowed the escalation of risk, workforce, performance and financial issues.
- All services held up to date risk registers, however risk escalation and meeting attendance in outpatients was less robust.
- The trust had implemented a new policy for the management of serious incidents, providing clear guidance and documentation for staff. Our review of serious incident investigations indicated that root cause analysis was largely well considered.
- The trust had struggled to meet its target response time for complaints for the twelve months preceding the inspection. Immediately prior to the inspection the backlog was cleared with the use of additional resource. However, at the time of inspection it was not possible to ascertain whether this could be sustained.

## **Organisational culture**

- In our report from the August 2015 inspection we reported a helpful engaging workforce (in terms of the inspection itself) that also felt pockets of bullying and harassment existed.



# Summary of findings

- The trust has had poor results within the national staff survey in past years. Results for 2016 have significantly improved with a notable increase in response rate to 49.5% against a national average of 40%.
- Detail relating to the organisational indicators showed 5 of the 7 indicators had significantly improved including a 10% rise in staff who recommend the trust as a place of work.
- Similarly indicators relating to managers also improved in 6 of 11 indicators including a greater than 10% increase regarding effective communication between senior management and staff.
- Indicators relating to the job of staff also showed improvement in 18 of 27 indicators with no indicators deteriorating. The biggest rise (7%) was in the extent with which staff are satisfied that the organisation values their work.
- The only indicator that deteriorated was relating to placing pressure on ones self to attend work when unwell. 4 of 7 indicators relating to appraisal also improved including an 11% rise relating to the discussion of organisational values during appraisal.
- Our findings during the inspection largely supported the results indicated in the staff survey. Many staff commented on improved morale, increasing positive feedback and a sense that the trust, as a whole, was moving in the right direction. There were also indications that feelings of bullying and harassment had reduced.
- However, there remains pockets within the trust where staff feel exhausted and under intense pressure. In addition, some staff reported a lack of involvement in key decisions.
- The trust last reported to board regarding equality and diversity in July 2016. This report acknowledged the trust had not been meeting contractual and statutory requirements relating to equality and diversity. Subsequent to this report the trust had implemented equality objectives and established an equality and diversity group.
- The trust reported against the workforce race equality standard in July 2016. Data from the staff survey indicated that BME staff have less belief that the trust provided equal opportunities than white staff.
- The board membership does not reflect the ethnic mix of voting members and has no BME members.

## Staff and patient engagement

- In August 2015, the report detailed very poor findings in national staff survey and that there was a hostility towards management from clinicians.

# Summary of findings

- The trust has delivered a much enhanced communications strategy. This includes face to face forums, newsletters, briefings and guidance. Importantly staff widely acknowledge this as helpful, informative and effective in maintaining a clarity of direction and delivery.
- The trust had surveyed staff to obtain information regarding modes of communication with 88% of staff surveyed indicating they felt well informed.
- The trust website has been updated to reflect vision, values and strategy and provides access to information for the public.
- The trust utilises social media effectively to inform and engage the public. The trust also publishes a news paper and holds open forums for the public.
- The trust had extensively engaged with staff, patients and visitors in order to attain a smoking free hospital environment.

## **Innovation, improvement and sustainability**

- Our report following the August 2015 inspection indicated weak processes for supporting innovation, improvement and sustainability.
- The trust now has a clear programmed approach to delivering sustainable change both for clinical services and finance.
- Change is supported by a programme management office that had director level leadership. The PMO was providing detailed information regarding planning, delivery and accountability of the change programme.
- The trust faces a large financial deficit. However, there was a financial recovery programme which although rigorous in approach retained a quality of care focus. Processes for quality and diversity assessment for efficiency schemes were in place.
- The trust had responded to the Carter Report with a clear procurement strategy that supported the trusts overall financial recovery plan.
- The trust was highly engaged in local sustainability and transformation plans.
- Innovation was actively encouraged and we saw a number of examples of staff led change during our inspection of services.
- Of particular note was the research active nature of the critical team.

# Overview of ratings

## Our ratings for Medway Maritime Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Outstanding	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

## Our ratings for Medway NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall</b>	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

# Outstanding practice and areas for improvement

## Outstanding practice

- The neonatal unit improved their breast-feeding at discharge compliance rates from one of the lowest rates in the country to the highest. A critical care consultant, nurse practitioner, GP lay member and physiotherapist led an innovative programme to improve patient rehabilitation during their ICU admission and after discharge. This included a training and awareness session for all area GPs and a business case to recruit a dedicated rehabilitation coordinator. In addition, a critical care consultant had developed app software to be used on digital tablets to help communication and rehabilitation led by nurses. The consultant was due to present this at a critical care nurses rehabilitation group to gather feedback and plan a national launch.
- Critical care services had a research portfolio that placed them as the highest recruiter in Kent. Research projects were local, national and international and the service had been recognised as the best performer of the 24 hospitals participating in the national provision of psychological support to people in intensive care (POPPI) study. Research projects for 2016/17 included a study of patients over the age of 80 cared for in intensive care; a review of end of life care practices; a respiratory study and a study on abdominal sepsis.
- The 'Stop Oasis Morbidity Project' (STOMP) project had reduced the number of first time mothers suffering third degree perineum tears. The project had been shortlisted for the Royal College of Midwifery Award 2017, Johnson's Award for Excellence.
- Team Aurelia was a multidisciplinary team. Women who were identified in the antenatal period as requiring an elective caesarean section would be referred to team Aurelia. Women were seen by an anaesthetist prior to surgery and an enhanced recovery process was followed to minimise women's hospital stays following surgery.
- The bereavement suite, Abigail's Place, provided the "gold standard" in the provision of care for parents and families who experience a still birth. The suite created a realistic home environment for parents to spend time with their child.
- The frailty and the ambulatory services, which required multidisciplinary working to ensure the needs of this patient group, were met. The individualised care and pathway given to patients attending with broken hips. The care ensured this group of patients' needs were met on entering the department until admission to a ward. The development and implementation of the associate practitioner role.
- The 'Stop Oasis Morbidity Project' (STOMP) project had reduced the number of first time mothers

## Areas for improvement

### Action the trust MUST take to improve

- Ensure flooring within services for children and young people is intact, in accordance with Department of Health's Health Building Note 00-09.
- Ensure all staff clean their hands at the point of care in accordance with the WHO 'five moments for hand hygiene'.
- Review the provision for children in the recovery area of theatres and Sunderland Day Unit to ensure compliance with the Royal College of Surgeons, standards for children's surgery.
- Ensure staff record medicine fridge temperatures daily to ensure medicines remain safe to use.
- Ensure compliance with recommendations when isolating patients with healthcare associated infections.

## Outstanding practice and areas for improvement

- Ensure that all staff have appropriate mandatory training, with particular reference to adult safeguarding level two and children safeguarding levels two where compliance was below the hospital target of 80%. Ensure that all staff receive an annual appraisal.
- Ensure that an appropriate policy is in place ensuring that patients transferred to the diagnostic imaging department from the emergency department are accompanied by an appropriate medical professional.
- Ensure the intensive care unit meets the minimum staffing requirements of the Intensive Care Society, including in the provision of a supernumerary nurse in charge.
- Ensure staffing levels in the CCU maintain a nurse to patient ratio of 1:2 at all times.
- Ensure that consultant cover in the emergency department meets the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine.
- Ensure fire safety is a priority. Although the trust has taken steps to make improvements we found some areas where fire safety and staff understanding needed to be improved.
- The trust must ensure people using services should not have to share sleeping accommodation with others of the opposite sex. All staff to be trained and clear of the regulation regarding same sex accommodation.
- Ensure clinical areas are maintained in a clean and hygienic state, and the monitoring of cleaning standards falls in line with national guidance. Take action to ensure emergency equipment (including drugs) are appropriately checked and maintained.

# Requirement notices

## Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>Regulation Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10 (2) (a)</p> <p>How this regulation was not met:</p> <p>Privacy, dignity and/or safety had been compromised where in some instances people using services had to share sleeping accommodation with others of the opposite sex.</p>
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>How this regulation was not met:</p> <p>Consultant cover within the emergency departments does not meet the minimum requirements of 16 hours per day, as established by the Royal College of Emergency Medicine. Patients transferred to the diagnostic imaging department from the emergency department were not always accompanied by an appropriate medical professional. The intensive care unit did not always meet the minimum staffing requirements of the Intensive Care Society, including in the provision of a supernumerary nurse in charge. Staffing levels in the CCU did not always maintain a nurse to patient ration of 1:2 at all times.</p>
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>18(2) (a) The provider must ensure appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the</p>

# Requirement notices

duties they are employed to perform. How this regulation was not met:Some staff did not have an up to date appraisal in line with trust policy.Some staff were not up to date with their mandatory training including safeguarding training in line with trust policy.

Regulated activity	Regulation
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Treatment of disease, disorder or injury

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

12(2) (h) The provider must assess the risk of, and prevent, detect and control the spread of, infections. How this regulation was not met:

We found some staff not cleaning their hands at the point of care in accordance with the WHO 'five moments for hand hygiene'We found the trust did not always follow recommendations when isolating patients with healthcare associated infections.The frequency of cleaning audits did not meet the national specification for cleanliness.The flooring within services for children and young people was not intact, in accordance with Department of Health’s Health Building Note 00-09.

Regulated activity	Regulation
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Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12 (2) (d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way **How this regulation was not met:**The provision for children in the recovery area of theatres and Sunderland day unit did not ensure compliance with the Royal College of Surgeons, standards for children’s surgery.

Regulated activity	Regulation
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Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

## Requirement notices

12 (2) (g) the provider must ensure the proper and safe management of medicines.

**How this regulation was not met:**

Medicine fridge temperatures were not recorded daily to ensure medicines remain safe to use. We found 11 vials of out-of-date Dantrolene on an emergency toxicity trolley in main theatres. We found an unlocked drugs cupboard containing medicines to take out on Phoenix Ward. We also saw evidence of intravenous drug administration on Phoenix Ward that was not in line with Nursing and Midwifery Council (NMC) Standards for Medicines Management. This was because two members of staff had not signed to confirm they had set up and checked the administration of an intravenous (IV) drug on two patients' MAR charts.